

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

## CERTIFICATE OF DEATH

12542

Reg. Dist. No. 3500

## 1. PLACE OF DEATH

County Worcester  
 City or town Pocomoke  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 85 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Worcester  
 City or town Pocomoke City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Jessie Armstrong

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Emory Armstrong  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) 1861  
 8. AGE: 85 Years Months Days If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Pocomoke, Worcester Md  
 (Town, county, and state)

10. Usual occupation Farm labor

11. Industry or business \_\_\_\_\_

12. Name Thomas Armstrong

13. Birthplace Maryland

14. Maiden name Unknown

15. Birthplace \_\_\_\_\_

16. Informant Joseph Armstrong

Address Pocomoke Md

17. Burial Date thereof Jan 1, 1949  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium Halls Hall Baptist

Location Rural Pocomoke City Md

18. Funeral director Johnson & Sons

Address Pocomoke City Md

19. Jan 2 1947 Anne E. White  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1946 at 1245 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 18th 1946 to Dec 29th 1946 and that I last saw him alive on Dec 29th 1946

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Due to Chronic Hypertension \_\_\_\_\_ years

Due to \_\_\_\_\_

Other conditions acute infection \_\_\_\_\_ weeks

Partial prostatic 1 ad \_\_\_\_\_ years

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_ Date of op. \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

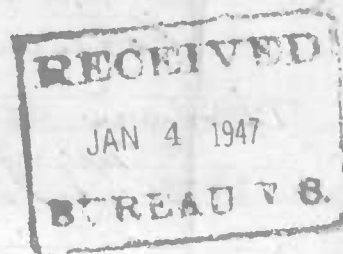
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE M. E. Antomius M. D. or other \_\_\_\_\_  
 Address Pocomoke City Md Date signed 12/30/46



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

## CERTIFICATE OF DEATH

Reg. Dist. No. 8550

## 1. PLACE OF DEATH:

County WorcesterCity or town Berlin

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County WorcesterCity or town Berlin

(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Della Kelly Brittingham

## 3. (b) Social Security Number

4. Sex Female5. Color or race white6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife George W. Brittingham

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Mar. 20, 18748. AGE: Years 72 Months 9 Days 1 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Berlin, Wm Co. Md R 7 D

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name John Edward Kelly13. Birthplace Maryland14. Maiden name Elen Payne15. Birthplace Maryland16. Informant Miss Lida BrittinghamAddress Berlin Md17. Burial Date thereof 12/23/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory EvergreenLocation Berlin Md18. Funeral director James A. BurkholderAddress Berlin Md19. 12/29 1946 Elen L. Hayward

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22 46 at 3:00 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-10 1946 to 12-22 1946and that I last saw him or alive on 12-21-46 1946Immediate cause of death Cerebral Hemorrhage

DURATION

Due to \_\_\_\_\_

Due to Hypertension

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town)

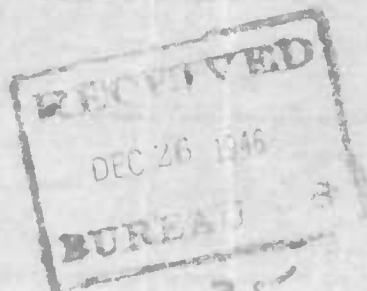
(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Clifford E. SchellM. D. reachesAddress Berlin Md Date signed \_\_\_\_\_



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

## CERTIFICATE OF DEATH

Reg. Dist. No. 12544350 d

## 1. PLACE OF DEATH

County WorcesterCity or town Pocomoke City  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 85 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Pocomoke City  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Katherine Brittingham

## 3. (b) Social Security Number

✓4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Edward J. Brittingham7. Birth date of deceased (mo., day, yr.) August 16-1860 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Year 86 Months 4 Days 3 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.9. Birthplace Pocomoke, Worcester Md.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business ✓12. Name Thomas Lambden13. Birthplace Maryland14. Maiden name Katherine Brittingham15. Birthplace Maryland16. Informant Mrs. Laura TurnerAddress Pocomoke City Md.17. Burial Date thereof Dec 22-1946  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Fifth Creek Baptist Ch.Location Rural Pocomoke Md.18. Funeral director Glenn E. L. LathamAddress Pocomoke City Md.19. Dec 22 1946 Ann E. White  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 46 at 11:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1946 to Dec 19 1946and that I last saw her alive on Dec 18 1946Immediate cause of death Bronchial Pneumonia DURATION 1 wk.Due to Senility

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

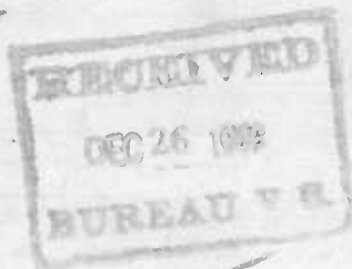
23. SIGNATURE Louis S. Clewely, MD M. D. or other \_\_\_\_\_Address Pocomoke City, Md. Date signed 12-21-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1310

## CERTIFICATE OF DEATH

12545  
Reg. Dist. No. 3550

### 1. PLACE OF DEATH:

County Worcester  
City or town Berlin  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Worcester  
City or town Berlin  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Mary Catherine Burbage

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced widow

6. (b) Name of husband or wife Charles H Burbage 6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1863

8. AGE: Years 83 Months 0 Days 20 If less than one day hrs. min.

9. Birthplace Berlin W.D. & Md.  
(Town, county, and state)

10. Usual occupation Housewife

### 11. Industry or business

12. Name Emma P. Davis 13. Birthplace Maryland

14. Maiden name Ellen Clayville 15. Birthplace Maryland

16. Informant Mrs. Harry Davis

Address Berlin Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 12/27/46  
(month) (day) (year)

Cemetery or crematory Evergreen Cem  
Location Berlin Md

18. Funeral director Dora A. Burbage

Address Berlin Md

19. 12-27-46 Helan F. Hayward Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1946 at 4:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-1-46 to 12-25-46

and that I last saw him alive on 12-25

Immediate cause of death Chronic Myocarditis DURATION

Due to Hypertension

Due to Chronic Int. Nep.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury Injured at work?

23. SIGNATURE Clifford E. Schott M. D. or other  
Address Berlin Md Date signed 12/26/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JAN 4 1947  
BUREAU 78

2-35



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

3550

## 1. PLACE OF DEATH:

County Prince George's  
 City or town Berlin R.D. 2  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life time  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution? x

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Wor  
 City or town Berlin  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Rt 1  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Charles H. Black

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Annie Black  
 6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1969  
 8. AGE: Years 27 Months May Days 7 If less than one day hrs. 50 min.

9. Birthplace Whites Island md.  
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Albertus Black  
 13. Birthplace md

14. Maiden name Annie Layton  
 15. Birthplace md

16. Informant William H. Black  
 Address Virginia

17. Buried Date thereof Dec 29-1968  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Taylorville md  
 Location near Berlin md

18. Funeral director M. Pasha Watson & Co  
 Address Sebyville Del

19. 12-29-68 Helen E. Hayward  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27 1968 at 6:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-26 1968 to 12-27 1968  
 and that I last saw him alive on 12-26-68 1968

Immediate cause of death Chronic Myocarditis DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

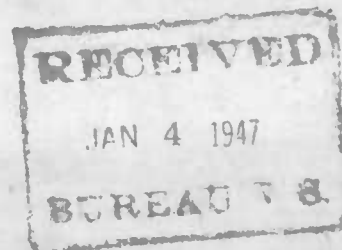
22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clifford E. Schott M. D. Seabrook  
 Address Berlin md Date signed



2-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 834

## CERTIFICATE OF DEATH

Reg. Dist. No. 12547 3550

## 1. PLACE OF DEATH:

County WorcesterCity or town Berlin RFD  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

2 YEAR.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WorcesterCity or town Berlin RFD  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

STEPHEN CZAPP.

## 3. (b) Social Security Number

4. Sex \_\_\_\_\_ 5. Color or race \_\_\_\_\_ 6.(a) Single, married, widowed, or divorced \_\_\_\_\_

MALE WHITE MARRIED6.(b) Name of husband or wife MARY CZAPP.6.(c) If alive, give age 43 years7. Birth date of deceased (mo., day, yr.) NOV. 26, 18938. AGE: Years 53 Months 1 Days 0 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace MONDOK, HUNGARY.  
(Town, county, and state)10. Usual occupation FARMER

11. Industry or business \_\_\_\_\_

12. Name ALEX CZAPP.13. Birthplace HUNGARY14. Maiden name UNKNOWN15. Birthplace HUNGARY16. Informant Mrs. MARY CZAPP.Address BERLIN, MD RFD 217. BURIAL Date thereof 12/29/46  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory EVERGREENLocation BERLIN, MD18. Funeral director ANNA H. BURRAGEAddress BERLIN, MD19. 12 29 46 Helen J. Hayward  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1946, at 6 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1946, to Dec 26 1946and that I last saw him alive on Dec 26 1946

Immediate cause of death \_\_\_\_\_

DURATION

Pneumonia pneumonia 1 yearDue to Cerebral thrombosis 3 m.Due to hypostatic pneumonia 2 days

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert S. Long

M. D. or other

Address Frankford Date signed 12-28-46

RECEIVED

JAN 4 1947

BUREAU V.S.

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1602

## CERTIFICATE OF DEATH

12548

Reg. Dist. No. 3540

## 1. PLACE OF DEATH:

County Worcester  
 City or town New Hope, PA (Scarborough Switz) County Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

City or town New Hope Md. Rural (Scarborough Switz) County Worcester  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Not Named

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

Caucasian

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife \_\_\_\_\_

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of

deceased (mo., day, yr.)

Dec. 20, 1946

8. AGE:

Years

Months

Days

if less than one day

82 hrs.

min.

9. Birthplace

Scarborough Switz, Md  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name

Arnie Werner

13. Birthplace

Rockton Md

14. Maiden name

Charlotte Schoenfeld

15. Birthplace \_\_\_\_\_

16. Informant

Arnie S. Lewis

Address

Scarborough Switz Md

17. Burial

(Burial, cremation, or removal. Which)

Date thereof

Dec. 23, 1946  
(month) (day) (year)

Cemetery or crematory

Holmes Center

Location

New Hope Md

18. Funeral director

Barbara Bennett

Address

Rockton Md

19. Dec 23

(Date rec'd by registrar)

1946

Mary M. Taylor

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 221946

at

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

21 Dec1946

to

22 Dec1946

and that I last saw h.r. \_\_\_\_\_

alive on

22 Dec1946

Immediate cause of death

Cerebral Hemorrhage

DURATION

2 days

Due to

Cerebral Pelvic Rupture

Due to

Anomalous Presentation

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_

Date of \_\_\_\_\_

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE

Heenan & Pabloski

M. D. or other

Address

Shawville 12

Date signed

23 Dec 46

RECEIVED  
DEC 30 1946  
BUREAU V.B.

2-35



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12

## CERTIFICATE OF DEATH

 ★ 12549  
 Reg. Dist. No. 3550

## 1. PLACE OF DEATH:

County Worcester  
 City or town Synanonant near Berlin  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred: no  
 How long in hospital or institution? no

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Worcester  
 City or town Berlin R.D.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. no  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war no

## 3. (a) FULL NAME

May Ida Hooks

## 3. (b) Social Security Number

no

4. Sex female 5. Color or race W.A. 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Lambert Hooks

7. Birth date of deceased (mo., day, yr.) Dec 16 1890 6. (c) If alive, give age Don't know years

8. AGE: Years about 55 Months 11 Days 14 If less than one day hrs. min.

9. Birthplace Synanonant md  
 (Town, county, and state)

10. Usual occupation housewife

11. Industry or business same as above

12. Name Alfred Smak

13. Birthplace Synanonant md

14. Maiden name Mary Smak

15. Birthplace Synanonant

16. Informant and Lambert Hooks

Address Berlin md

17. Burial Date thereof Dec 4-46  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Family Synanonant

Location Synanonant

18. Funeral director James H. Stewart

Address Salisbury md

19. 12-4 46 Helen F. Hayward  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Dec 1946, at 4:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1946, to Dec 1946

and that I last saw her alive on 30 Nov 1946

Immediate cause of death Lo Car pneumonia DURATION 7 days

Rt Lower Lobe

Due to

Due to

Other conditions hypertensive Cardio

Vascular disease 1 Year

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, IIII in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

Signature Ernie B. McCay M. D.

Address Dean City Md Date signed 3 Dec

RECEIVED

RECEIVED

RECEIVED  
DEC 5 1946  
BUREAU V.S.

1-35

AMERICAN INDIAN

CONTENT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

125513570  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County Worcester  
City or town Frederick Rural # 1  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 30 years  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Harry Lee Hastings

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Clara J. Hastings

7. Birth date of deceased (mo., day, yr.) May 11 - 1894 6. (c) If alive, give age 49 years

8. AGE: Years 62 Months 6 Days 29 If less than one day  
..... hrs. .... min.

9. Birthplace Frederick, Worcester, Md  
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Own Farm

12. Name John H. Hastings

13. Birthplace Maryland

14. Maiden name Mrs. Gene Marshall

15. Birthplace Maryland

16. Informant Mrs. Clara J. Hastings

Address Frederick, Md Rural #1

17. Burial (Burial, cremation, or removal, Which?) Date thereof Dec 13/46  
(month) (day) (year)

Cemetery or crematory Episcopal

Location Frederick

18. Funeral director Clara E. Dimes

Address John Hill, Md

19. 12/12/46 (Date rec'd by registrar) 19 46 Recey Smith Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Worcester  
City or town Frederick Rural # 1  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. ....  
(If rural, give LOCATION) 70

2. (a) If veteran, name war

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 10 19 46 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 Dec 19 46 to 10 Dec 19 46  
and that I last saw him alive on 10 Dec 19 46

Immediate cause of death  
Chronic Degeneration  
myocarditis  
Due to asthma bronchial

Due to

Other conditions Marasmus

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Shamara Ralston, M.D.  
M. D. or other

Address John Hill, Md Date signed 11/4/46

RECEIVED  
DEC 14 1946  
BUREAU OF

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

## CERTIFICATE OF DEATH

Reg. Diat. No. 3530

## 1. PLACE OF DEATH:

County Monrovia  
 City or town Bishopville Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Monrovia  
 City or town Bishopville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Rural  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Millie Kate Hemphill

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widow

## 6. (b) Name of husband or wife

William Hemphill

## 7. Birth date of

deceased (mo., day, yr.)

May 8 1878

## 8. AGE:

68

Years

7

Months

15

Days

If less than one day

hrs.

min.

## 9. Birthplace

Maryland  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

Remberton, Hickman

## FATHER

## 12. Name

## 13. Birthplace

## MOTHER

## 14. Maiden name

## 15. Birthplace

## 16. Informant

## Address

## 17. Burial

## Cemetery or cremation

## Location

## 18. Funeral director

## Address

## 19.

(Date rec'd by registrar)

12/14/46  
Mrs. Ray Beyer  
Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Dec 13, 1946 at 9:00 P.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1946 to day of death  
and that I last saw her alive on 12-5-46

## Immediate cause of death

Adenocarcinoma of  
her left breast, metastasized

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

## Accident, suicide, or homicide

## Date of

## Where did injury occur?

(City or town)

(County)

(State)

## Injured at home, farm, industry, public place (where?)

## Means of injury

## Injured at work?

## 23. SIGNATURE

Frank R. Lewis M.D.  
Millard M.D.

M. D. or other

Date signed 12-13-46

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DEC 19 1946

BUREAU

2-35



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12552

Reg. Dist. No.

3570

## 1. PLACE OF DEATH:

County..... Worcester  
 City or town..... Yonkers Rural #1  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 14 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Worcester  
 City or town..... Yonkers Rural #1  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)..... 70  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Widowed  
 6.(b) Name of husband or wife..... Charles Jackson  
 7. Birth date of deceased (mo., day, yr.)..... Sept 11 - 1902 6.(c) If alive, give age..... years

8. AGE: Years..... 44 Months..... 3 Days..... 8 If less than one day..... hrs..... min.

9. Birthplace..... Yonkers, Worcester, Md  
 (Town, county, and state)

10. Usual occupation..... Housewife11. Industry or business..... Own Home12. Name..... Walter Bradford13. Birthplace..... Maryland14. Maiden name..... Sarah Ellis15. Birthplace..... Maryland16. Informant..... W. George W. JacksonAddress..... Yonkers, Md Rural #1

17. Burial (Burial, cremation, or removal, Which?) Date thereon..... Dec 21/46  
 (month) (day) (year)

Cemetery or crematory..... BowersLocation..... Yonkers, Md18. Funeral director..... May E. DennisAddress..... 12th St, 46 Le Roy Smith

19. 12th St, 46 (Date rec'd by registrar) Registrar.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 19 19..... 46, at..... 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....  
 and that I last saw him..... alive on..... 19.....

Immediate cause of death..... Myocardial degeneration of heart chronic nephritis and gangrene of rt leg  
 Due to..... unknown  
 Due to.....

Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Yes Date of.....  
 Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?.....

23. SIGNATURE..... John L. Riley, M.D. M. D. or other.....  
 Address..... Shawnee Date signed..... 12/30/46

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DEC 23 1946

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12553  
3500  
Reg. Dist. No.

### 1. PLACE OF DEATH:

County Worcester  
City or town Pocomoke  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 37 years  
Hospital, institution, or street address where death occurred: ✓  
How long in hospital or institution? ✓

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Worcester  
City or town Rural Pocomoke City  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. ✓  
(If rural, give LOCATION)  
2.(a) If veteran, name war ✓

### 3. (a) FULL NAME

Filmore Dennis James

### 3. (b) Social Security Number

717-07-9097

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife ✓

7. Birth date of deceased (mo., day, yr.) Aug 25 - 1907

8. AGE: Years 39 Months 4 Days 4 It less than one day ✓ hrs. min.

9. Birthplace Rural Pocomoke Worcester Maryland  
(Town, county, and state)

10. Usual occupation  labor at packing house

11. Industry or business ✓

12. Name Edward V. James

13. Birthplace md.

14. Maiden name Annie F. Smith

15. Birthplace md.

16. Informant Annie F. James

Address Rural Pocomoke City Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Jan 1, 1947  
(month) (day) (year)

Cemetery or crematory Unionville Cemetery

Location Rural Pocomoke City Md.

18. Funeral director Henry G. Gledhill

Address Pocomoke City Md.

19. Jan. 2, 1947 Anne E. White  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 29, 1946, 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1, 1947 to Jan 1, 1947

and that I last saw him alive on Jan 1, 1947

Immediate cause of death Hemorrhage of lung

Due to Putridity T. b. lungs

Other conditions Influenza

(Include pregnancy within 3 months of death)

Major findings of operations ✓

Date of op. 7 weeks

Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide ✓ Date of Jan 1, 1947

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ✓ Injured at work? ✓

23. SIGNATURE J. E. Carlowitz

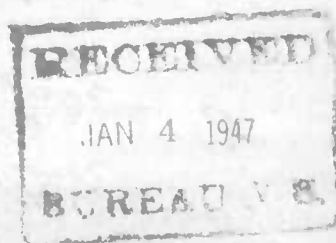
Address Forman City Md.

Date signed 12/30/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 99

## CERTIFICATE OF DEATH

12554

Reg. Dist. No.

3550

## 1. PLACE OF DEATH:

County Worcester  
 City or town Berlin  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 years  
 Hospital, institution, or street address where death occurred

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Worcester  
 City or town Berlin  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

William Marshall

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced widower

6.(b) Name of husband or wife Alva Marshall

7. Birth date of deceased (mo., day, yr.) May 27, 1867

8. AGE: Years 79 Months 6 Days 27 If less than one day hrs. min.

9. Birthplace Cincinnati, Ohio  
 (Town, county, and state)

10. Usual occupation Painter

11. Industry or business

12. Name Robert Marshall13. Birthplace Ireland14. Maiden name Anna Bohlander15. Birthplace Holland16. Informant Dr. William H. Marshall

Address Pittsville, Md R 2D

17. Burial Date thereof 12/27/46  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Evergreen  
Berlin Md.

18. Funeral director Anna A. Burba  
 Address Berlin Md

19. 12-27 19 46 Helen F. Hayward  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 19 46 at 9 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-14 19 46, to 19

and that I last saw him alive on 19

Immediate cause of death Chronic Aortitis DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Autopsy results None Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ✓

Means of injury ✓ Injured at work?

SIGNATURE Clifford E. Schott M. D. or other

Address Berlin Md Date signed 12/26/46

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

12555  
Reg. Diat. No. 3570

### 1. PLACE OF DEATH:

County Worcester  
City or town Newark Rural #1  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 20 years  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Worcester  
City or town Newark  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Charles H. Pennewill

### 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Bertie C. Pennewill

7. Birth date of deceased (mo., day, yr.) April 2 - 1869 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: 77 Years 8 Months 8 Days 0 hrs. 0 min.

9. Birthplace Snow Hill, Worcester, Md  
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Pennewill M. Pennewill

13. Birthplace Maryland

14. Maiden name Nattie A. Jackson

15. Birthplace Maryland

16. Informant Mr. Luther C. Pennewill

Address Newark, Md Rural #1

17. (Burial, cremation, or removal. Which?) Burial Date thereof Dec 12/46  
(month) (day) (year)

Cemetery or crematory Whitcomb

Location Snow Hill, Md

18. Funeral director Elmer C. Smith

Address Snow Hill, Md

19. 12/12/46 46 Elmer C. Smith  
(Date rec'd by registrar) (Year) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 10, 1946 at 2:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 day to 10 days and that I last saw him alive on 10 days

Immediate cause of death Chronic Myocarditis DURATION \_\_\_\_\_

Due to Branchitis Chronica, Bronchilectomia

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Meane of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Harmon A. Hobbs Jr M. D. or other \_\_\_\_\_

Address Franklin, Md Date signed 11 Dec 46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DEC 14 1946

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

## CERTIFICATE OF DEATH

12556

Reg. Dist. No. 3510

### 1. PLACE OF DEATH:

County Worcester  
City or town Guddelee  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 30 years  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Worcester  
City or town Guddelee  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war.

### 3. (a) FULL NAME

Ethel H. Pilchard

### 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.) August 21- 1892 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 54 Months 3 Days 27 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Worcester, Md  
(Town, county, and state)

10. Usual occupation.

11. Industry or business

12. Name Joseph W. Pilchard  
13. Birthplace Maryland

14. Maiden name Susan J. Hancock  
15. Birthplace Maryland

16. Informant M. Russell B. Pilchard  
Address Guddelee, Md

17. Burial (burial, cremation, or removal, which?) Burial Date thereof Dec. 20/46  
(month) (day) (year)

Cemetery or crematory Bethel  
Location Guddelee, Md

18. Funeral director Wm. O. Dennis  
Address Intown Hall, Md

19. 12/20/46 19 \_\_\_\_\_  
(Date rec'd by registrar) Registrar Re. Day Smith

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 18 19 46 at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15 19 46 to Dec 18 19 46  
and that I last saw him alive on Dec 18 19 46

Immediate cause of death Myocardial Infarction DURATION 4 days

Due to Hypertension

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Hermana Robbin M. D. or other \_\_\_\_\_  
Address Brownsville, Md Date signed 12/20/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DEC 23 1946

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53)

## CERTIFICATE OF DEATH

12557

Reg. Dist. No. 3550

### 1. PLACE OF DEATH:

County Worcester

City or town Berlin  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Worcester

City or town Berlin  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Spencer  
(If rural, give LOCATION)

2.(a) If veteran, name war Spencer

### 3. (a) FULL NAME

Dr. Harry Selby Purnell

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Elizabeth K. Purnell

6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1879

8. AGE: Years 67 Months 3 Days 17 It less than one day hrs. min.

9. Birthplace Berlin, Worcester Co. Md.  
(Town, county, and state)

10. Usual occupation Retired army doctor

### 11. Industry or business

12. Name William S. Purnell

13. Birthplace Md.

14. Maiden name Sarah Funnions

15. Birthplace Md.

16. Informant Dr. Harry S. Purnell Jr.

Address Berlin, Md.

17. Buried Date thereof 12/22/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Paul's

Location Berlin Md.

18. Funeral director Dune A. Burbanck

Address Berlin Md.

19. Dec 22 1946 Helen F. Hayward  
Date rec'd by registrar Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 12-20 at 9:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-1-46 1946 to 12-20-46 1946

and that I last saw him alive on 12-20-46 1946

Immediate cause of death Tuberculosis

Due to Chronic Dist. Neph.

Due to Cancer (Skin)

Other conditions Cancer (Skin)

(Include pregnancy within 3 months of death)

Major findings of operations Chronic Dist. Neph.

Autopsy results Cancer (Skin)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Chronic Dist. Neph. Date of 12-20-46

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) (City or town) (County) (State)

Means of injury Chronic Dist. Neph. Injured at work?

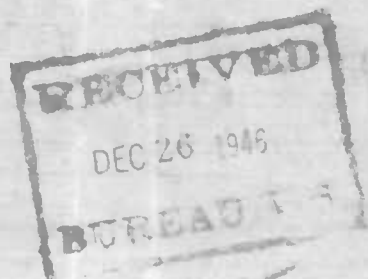
23. SIGNATURE Oliver E. Schott M.D. M. D. or other

Address Berlin Md. Date signed 12/21/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 737

## CERTIFICATE OF DEATH



12558

Reg. Dist. No.

3550

## 1. PLACE OF DEATH:

County Worcester  
 City or town Berlin R.T.D.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 88 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State md. County Worcester  
 City or town Berlin  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Levin S. Zullien

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white single

6. (b) Name of husband or wife

6. (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1858

8. AGE: Years 88 Months 4 Days 26 If less than one day  
 hrs. min.

9. Birthplace Berlin, Wor. Co., Md.  
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Thomas Zullien13. Birthplace Berlin Md.14. Maiden name Catherine Smack15. Birthplace Berlin Md.16. Informant Mr. John ZullienAddress Berlin Md. R.T.D.17. Burial Date thereof Jan 11/49  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory EvergreenLocation Berlin Md.18. Funeral director Diana H. BurbanAddress Berlin Md.19. 12-31- 46 Helen I. Hayward  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-30 46 at 6 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-24 46 to 12-30 46and that I last saw him alive on 12-29-46 19

Immediate cause of death

Chronic myocarditisDue to My-peritension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

William E. Dehart  
Berlin Md. M. D. or other  
 Address Date signed 12/31/46

Worcester

Mr.

Mr. J. Edgar Hoover  
Washington, D.C.  
January 28

Dear Mr. Hoover:

Very truly yours,

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JAN 4 1947  
BUREAU 18.

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Very truly yours,  
J. Edgar Hoover  
Director, FBI

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

## CERTIFICATE OF DEATH

 ★ -12559  
 Reg. Dist. No. 3570

<b>1. PLACE OF DEATH:</b> County <u>Newark</u> City or town <u>Newark</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>46 years</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Newark</u> City or town <u>Newark</u> (If outside city or town limits, write RURAL and give nearest town) Street No. (If rural, give LOCATION) <u>70</u> 2.(a) If veteran, name war			
<b>3. (a) FULL NAME</b> <u>Luitta C. Smack</u>				<b>3. (b) Social Security Number</b> <u>None</u>			
<b>4. Sex</b> <u>Female</u>				<b>5. Color or race</b> <u>White</u>			
<b>6. (b) Name of husband or wife</b> <u>Arthur P. Smack</u>				<b>6. (c) If alive, give age</b> <u>72</u> years			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>Feb. 2 - 1881</u>				<b>8. AGE:</b> Years <u>65</u> Months <u>10</u> Days <u>13</u> If less than one day . hrs. min.			
<b>9. Birthplace</b> <u>Victor Rock, Pa.</u> (Town, county, and state)				<b>10. Usual occupation</b> <u>Housewife</u>			
<b>11. Industry or business</b> <u>Home</u>				<b>12. Name</b> <u>George Thomas</u>			
<b>13. Birthplace</b> <u>Pa.</u>				<b>14. Maiden name</b> <u>Unknown</u>			
<b>15. Birthplace</b>				<b>16. Informant</b> <u>Mr. Arthur P. Smack</u> Address <u>Newark, Md.</u>			
<b>17. (Burial, cremation, or removal, Which?)</b> <u>Burial</u>				Date thereof <u>Dec. 17/46</u> (month) (day) (year)			
<b>Cemetery or crematory</b> <u>Bowen Methodist</u>				<b>Location</b> <u>Newark</u>			
<b>18. Funeral director</b> <u>Way E. Dammis</u> Address <u>Shaw Hill, Md.</u>				<b>19. (Date rec'd by registrar)</b> <u>12/16/46</u> <u>46</u> <u>Relay Smith</u> Registrar			
<b>MEDICAL CERTIFICATION</b>							
<b>20. DATE OF DEATH</b> <u>December 15</u> 19 <u>46</u> , at _____ M							
<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>15 Nov 46</u> to <u>15 Dec 46</u> and that I last saw him <u>alive</u> on <u>15 Dec 46</u> Immediate cause of death <u>Chronic degeneration</u> <u>myocarditis</u>							
<b>OURATION</b> <u>1 mo.</u>							
<b>Due to</b> <u>Chronic</u>							
<b>Due to</b>							
<b>Other conditions</b>							
(Include pregnancy within 3 months of death)							
<b>Major findings of operations</b>							
<b>Autopsy results</b>							
<b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>							
<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b> Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____							
<b>23. SIGNATURE</b> <u>Herman A. Nabhan</u> <u>MD</u> Address <u>Shaw Hill, Md.</u> Date signed <u>16 Dec 46</u> M. D. or other							

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3541

### 1. PLACE OF DEATH:

County Worcester

City or town Mr. Stockton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Mr. Stockton  
(if outside city or town limits, write RURAL and give nearest town)

Street No. —  
(If rural, give LOCATION)

2.(a) If veteran, name war —

### 3. (a) FULL NAME

Barbara A. Wallop

### 3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife —

7. Birth date of deceased (mo., day, yr.) October 3, 1946 6.(c) If alive, give age — years

8. AGE: Years 0 Months 2 Days 11 It less than one day — hrs. — min.

9. Birthplace Horn Town, Va  
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business —

12. Name Thomas Wallop

13. Birthplace Horn Town, Virginia

14. Maiden name Doris

15. Birthplace Horn Town, Virginia

16. Informant Thomas B. Wallop

Address Stockton, Md.

17. Burial Date thereof December 19, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Dees' Chapel

Location Horn Town, Virginia

18. Funeral director J. Edgar Thomas

Address Accomac, Virginia

19. Dec 16 19 46 Mary M Taylor  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

2D. DATE OF DEATH Dec 14 19 46 at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 13 19 46 to Dec 14 19 46

and that I last saw — alive on Dec 13 19 46

Immediate cause of death Bronchial pneumonia

DURATION

Due to —

Due to —

Other conditions —

(include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE — M. D. or other

Address — Date signed —

MARGIN RESERVED FOR BINDING

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

LOCAL BOARD OF HEALTH

HEALTH DEPARTMENT

LOCAL BOARD OF HEALTH

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

## CERTIFICATE OF DEATH

 12561  
 3500  
 Reg. Dist. No.

## 1. PLACE OF DEATH:

County Worcester  
 City or town Pocomoke  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 90 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Worcester  
 City or town Pocomoke  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Edward W. White

## 3. (b) Social Security Number

✓

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Rebecca White

## 7. Birth date of deceased (mo., day, yr.)

June, 13-1855

## 6. (c) If alive, give age \_\_\_\_\_ year

## 8. AGE:

9163

If less than one day

\_\_\_\_\_ hrs. \_\_\_\_\_ min.

## 6. Birthplace:

Pocomoke, Worcester Md.  
(Town, county, and state)

## 10. Usual occupation:

Farming

## 11. Industry or business

MOTHER FATHER

## 12. Name:

John T. White

## 13. Birthplace:

Maryland

## 14. Maiden name:

Unknown

## 15. Birthplace:

Lloyd W. White

## 16. Informant:

Pocomoke Md.

## Address:

Burial

## 17.

(Burial, cremation, or removal. Which?)

Date thereof Dec 19-1946  
(month) (day) (year)

## Cemetery or crematory:

Salon M & Cemetery

## Location:

Pocomoke City Md.

## 16. Funeral director:

Henry J. Wideman

## Address:

Pocomoke City Md.

## 19.

Dec. 19, 1946  
(Date rec'd by registrar)Anne E. White  
Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH:

December 16, 1946, 8 AM

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 15, 1946, to Dec. 16, 1946

and that I last saw him alive on

Dec. 14, 1946

## Immediate cause of death:

Lobar Pneumonia

## DURATION

2 wks.

## Due to:

Senility

## Due to:

## Other conditions:

(Include pregnancy within 3 months of death)

## Major findings of operations:

Date of op. \_\_\_\_\_

## Autopsy results:

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

## Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

## Means of injury

Injured at work?

## 23. SIGNATURE

Louis J. Cleveland M.D.

Address:

Pocomoke CityDate signed 12-17-46



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